# Toward Sensible Rehabilitation Of the Alcoholic

By ANTHONY ZAPPALA, M.D., and FRANK S. KETCHAM, A.B., LL.B.

A DRAMATIC DEVELOPMENT over the last 20 years has been the emergence of alcoholism as a disease and public health problem. Within the memory of most Americans, the excessive use of alcoholic beverages, whatever its manifestation, has been regarded variously as a moral deviation, a misdemeanor, or a joke, depending on the point of view. Drunkards—the term "alcoholic" was little used—were thought of as perverse creatures, caught in a situation of their own making, whose natural habitat was the gutter, jails, flophouses, and the like. Twenty years ago, the concept of alcoholism as an illness found little acceptance. Society's attitude toward alcoholism was similar to society's attitude toward the psychoses until the late 18th century, when it was finally realized that the management of major personality disorders properly belongs in the medical field. Today, we are witnessing the same development with respect to alcoholism.

The founding of Alcoholics Anonymous in 1935 and the establishment of pilot clinics beginning with the Yale plan clinic in 1945 (*1*) threw new light not only on the nature of alcoholism but on its extent as a health problem. The new methods of treatment have been freely and eagerly embraced by thousands of persons who are far removed from the usual concept of "skid row" drunk but who nevertheless know and fear the effects of compulsive drinking. The majority of alcoholics do not belong to the submerged or social outcast group but are ordinary people, working, living in a family group, grappling with the day-to-day exigencies of life which for them center around a problem with alcohol.

*Dr. Zappala is the director of the alcoholic rehabilitation division, District of Columbia Department of Public Health, and assistant clinical professor of psychiatry, Georgetown University, Washington, D. C. Mr. Ketcham is a practicing attorney in the District and a member of the mental health committee of the District of Columbia Bar Association. Both authors have contributed articles to scientific journals, Dr. Zappala on the subject of alcoholism, and Mr. Ketcham on political, legal, and sociological subjects. Miss Mary K. Nesbit, an associate of Mr. Ketcham, assisted with technical research.*

## The Nature of the Problem

What is this problem of alcoholism?

The medical definition, which is gradually finding its way into the law, describes the alcoholic as a person who has lost control of the practice of drinking alcoholic beverages to an extent that his interpersonal, family, or community relationships have become seriously threatened or disturbed. The alcoholic drinks because in him exists an urgency in the form of tension, anxiety, or depression which irrationally drives him to alcohol and its excessive use. He drinks not to make reality more pleasant but to escape from reality. As a rule, the alcoholic hates liquor and hates himself for suc-

cumbing, but he cannot stop without help (*2*).

Selden D. Bacon (*3*) considers the alcoholic's drinking as compulsive as the behavior of the kleptomaniac or the continual handwashing of a compulsive neurotic. Compulsive drinking is a progressive condition, and the course may be rapid or very slow. The drinking behavior is a symptom of some inner maladjustment which the alcoholic cannot understand and cannot control. It is safe to say that the alcoholic's difficulties were seeded before he ever tasted alcohol.

Obesity is not caused by the availability of food, and, by the same token, alcoholism is not caused by the mere availability of liquor. It is a much more complex resultant of multiple interacting factors—biological, social, psychological, and cultural—which have combined to produce a personality disorder.

We now know that alcoholism is a public health problem, as much so as tuberculosis. It is estimated that there are 3,800,000 alcoholics in the United States, of whom 36,900 are located in the District of Columbia (*4*). Each year the monetary costs of alcoholism in terms of potential wage losses, accidents, hospital care, jail maintenance, and so forth, run into millions of dollars—$778,903,000 annually on a national basis, according to a recent estimate (*5*). And in the District of Columbia alone, more than $1 million is expended each year in the mere maintenance of alcoholics in the jail and workhouse.

In addition, and more importantly, alcoholism untreated leads to intangible costs which cannot be reckoned—the breakup of families, the dulling of fine minds, the warping of attractive personalities. This is borne out by case histories selected from records of the alcoholic rehabilitation division of the District of Columbia Department of Public Health, a few of which are briefly outlined below:

CASE 1. Female, 38 years of age, recently divorced. Cultured, widely traveled, above average in intelligence and personal charm, but markedly lacking in mature self-confidence. Very dependent. Alcoholism has long been a disrupting force in her life. Last year she was sober 3 months; drunk 6 months; spent 3 months in mental hospitals. Currently, she is serving her first sentence in the workhouse. This patient is poorly motivated but has sufficient insight to be aware of her desperate situation. She would accept treatment in an institution for alcoholics if facilities were available.

CASE 2. Male, 31 years of age, separated from his wife and child. Tall, strongly built, Viking type. By temperament, sensitive, perceptive, artistic. Displays considerable talent for self-expression through the medium of painting. Good general education, unusually well informed about many things, but not professionally trained. Frustration threshold is low, and he refuses to stick to humdrum, routine jobs. Not a chronic court repeater, but is now serving a sentence at the workhouse. Has qualities which should enable him to respond well to psychotherapy in a protected environment.

CASE 3. Female, 45 years of age, divorced. She fought the divorce suit vigorously but was unsuccessful, losing custody of her much loved only child and even visitation rights, which are granted sparingly. Throughout the marriage she contributed materially to the home, holding responsible positions as executive secretary in which she took great interest. She has been arrested for drunkenness, has served sentences, and in therapy speaks frequently of the traumatic effect of her first arrest. She still drinks—consistently and sometimes heavily. Her physical and psychological handicaps are such that only prolonged treatment in a sympathetic and protected environment would be helpful.

CASE 4. Male, 35 years of age, divorced. Skilled mechanic. Suffers from an obscure nervous condition which leads to compulsive drinking. Now far advanced in chronic alcoholism; value system completely undermined; physically deteriorated. Spends his time on circuit between the clinic, jail, workhouse, and municipal hospital. Prognosis for recovery of physical and mental health very poor without long-term treatment.

CASE 5. Female, 30 years of age, divorced 5 years ago after an early, unsuccessful marriage. Has a delicate prettiness of face and figure, like a Dresden china doll. College trained and qualified as a medical technician. She has a deeply rooted desire for oblivion. For this reason, and also, because of the stigma attached to the use of alcohol by a woman, she has turned to barbiturates or "sleeping pills," which when taken in excessive quantities produce the same effects as alcohol. Her problems are, of course, intensified by this additional addiction, which is even more dangerous and difficult to arrest than the alcohol habit. She has had no contact with the police, the family having extended itself to provide expensive hospital care, thus far to little avail. This patient needs additional treatment under close supervision in a protected environment.

CASE 6. Male, 39 years of age, unmarried. Has been a successful attorney. Arrested 80 odd times for intoxication. Has had brief contacts with the clinic, but since he spends practically all of his time at the workhouse, psychiatric diagnosis and treatment have not been possible.

Such examples, which are not unusual, show the compulsive nature of excessive drinking. Would any well-adjusted individual deliberately waste his abilities and "with malice aforethought" subject himself to the hardships which have been described?

We are living in a period of transition insofar as legislation on alcoholism is concerned. The situation in the District of Columbia is typical of the situation as it exists in almost every large city in the land. Two major statutes in the District deal with drunkenness and alcoholism—statutes which are in conflict. One treats public intoxication as a misdemeanor and prescribes penalties (*6*). The other embodies the modern concept of alcoholism as a disease and sets up a program for rehabilitation (*7*). These two approaches—the old and the new, the penal and the nonpenal—are operating side by side in the District, and in other cities as well, with results that are gratifying in some respects but on the whole are frustrating and incongruous.

Let us examine the situation in the District of Columbia. In this way, we may gain a view of the general situation, for the same conditions obtain everywhere, statistics forming the only material difference.

### Failure of the Penal Approach

Alcoholism has been regarded traditionally as a penal problem, and efforts have been made to control it by punitive measures. The District of Columbia statute—act of Congress approved 1934, as amended (*6*)—is typical. After providing that no person shall be drunk or intoxicated in any public place, it prescribes penalties: a fine of not more than $100 or imprisonment for not more than 90 days, or both.

It is estimated that not more than 10 to 20 percent of the alcoholic population ever comes in contact with the police. The rest are the hidden alcoholics—the ones who drink quietly and alone or who are protected by the family group. Alcoholics in the early and middle stages of the disease rarely come to the attention of the law enforcement officials. Thus, penal measures reach only the homeless, social misfit group of drinkers and others whose alcoholism is far advanced.

As nearly everybody knows, the attempt to arrest alcoholism by means of punitive measures has been a total failure. The penal approach has been thoroughly discredited as expensive, profitless, and inhumane. Other than the existence of statutes which still make public intoxication a misdemeanor and which should be replaced, there is no justification for sentencing alcoholics to penal institutions for fixed periods of custody and then releasing them. The nature of alcoholism is such that it is impossible to predict with any certainty the length of time required for recovery. If the patient is uncooperative and actually resists treatment, progress in changing his motivation is likely to be slowly achieved. Commitment? Yes—in the advanced cases—but it should be in a specially provided inpatient facility for an indeterminate period of whatever time is necessary to arrest the disease. There should also be provision for conditional release on extended visit status so that the patient may continue under the supervision of the rehabilitation staff while readjusting himself as a member of the community (*8*).

The tremendous monetary cost of the penal approach to alcoholism is reflected in an unpublished report of the director of the department of corrections of the District of Columbia which shows that on June 30, 1953, there were confined in correctional institutions of the District 3,868 prisoners of whom 1,017 were alcoholics. It costs $2.80 a day to maintain an inmate; his maintenance includes food and the personal services of attendants as well as plant maintenance.

At the rate of $2.80 each, the cost of maintaining the 1,017 alcoholics who were in custody of the department of corrections on June 30, 1953, was $2,847.60 for that day. Assuming that June 30 was an average day, the estimated annual cost of maintaining the alcoholic population of the District's correctional institutions is $1,039,374.

Thus, in the District of Columbia more than $1 million of the taxpayers' money is being expended annually on a method of dealing with alcoholism, which reaches, at best and at the most, not more than 20 percent of the alcoholic population and which, as shown by statistics on recidivism which will be quoted later in this

article, produces no tangible results in the form of rehabilitation.

If this money were devoted to more adequate rehabilitation facilities for alcoholics, we would be in a position to make an effective attack on the disease in all of its phases with prospects of great gains in human happiness and welfare.

Alcoholic rehabilitation programs are financed either by general tax funds or by a levy on liquor revenue, supplemented by fees from patients who are in a position to pay for treatment. The Alcoholic Rehabilitation Act of the District of Columbia (*9*) provides for a 6-percent tax on liquor licenses. This levy yields about $75,000 annually, which is earmarked for the operation of the alcoholic rehabilitation program in the District.

### Alcoholic Rehabilitation Program

The alcoholic rehabilitation program of the District of Columbia represents the new, disease-concept approach to the problem of alcoholism. The program has been established as a division within the District of Columbia Department of Health, although as just stated, its funds are separate from the general appropriation for health purposes in the District. The purposes of the District's program are set forth in the act of Congress approved August 4, 1947, as follows (*7*):

"The purpose of this chapter is to . . . provide for the medical, psychiatric, and other scientific treatment of chronic alcoholics; to minimize the deleterious effects of excessive drinking upon those who pass through the courts of the District of Columbia; to reduce the financial burden imposed on the people of the District of Columbia by the abusive use of alcoholic beverages, as is reflected in mounting accident rates, decreased personal efficiency, growing absenteeism, and a general increase in the amount and seriousness of crime in the District of Columbia, and to substitute for jail sentences for drunkenness medical and other scientific methods of treatment which will benefit the individual involved and more fully protect the public. In order to accomplish this purpose and alleviate the problem of chronic alcoholism, the courts of the District of Columbia are hereby authorized to take judicial notice of the fact that a chronic alcoholic is a sick person and in need of proper medical, institutional, advisory and rehabilitative treatment. . . ."

The alcoholic rehabilitation division of the District of Columbia Department of Public Health, an outpatient clinic for the rehabilitation of alcoholics who are residents of the District, was opened on February 1, 1950. The clinic offers a multipronged, multidisciplined approach to the rehabilitation of the alcoholic patient (*2*). Medical, social, psychiatric, and psychological diagnosis and therapy are employed to assist him to recover. The staff consists of 3 psychiatrists, 1 internist, 3 public health nurses, 3 social workers, 2 clinical psychologists, 5 clerks, and 4 recreation leaders, 3 of whom work on a part-time or volunteer basis.

Each new patient at the clinic receives a general physical examination and routine laboratory studies, including chest X-ray and blood test. Any organic difficulties are treated or referred to other community clinics or to private physicians. Diseases incidental to alcohol intoxication receive the special attention of the clinic physician.

One of the psychiatrists on the clinic staff makes a diagnostic appraisal of every patient, after which the patient is assigned to a therapist for a regular weekly interview at which job or family problems of a pressing nature, or significant past experiences, are analyzed for the purpose of discovering the cause of the patient's drinking, averting a recurrence, and facilitating betterment of the patient's way of life. Therapy is determined according to the patient's individual needs and ability to collaborate. Supportive or insight-gaining psychotherapy rather than deep analysis is employed.

Various forms of group therapy supplement individual therapy. Patients have responded to psychodrama with enthusiasm and enjoyment. They easily develop insight into their own and others' behavior during the acting of typical situations and during the discussion afterward.

Diagnostic intelligence and projective and aptitude tests are administered as an aid in treatment.

An appraisal of the patient's initial need is made, and appropriate casework activity is performed. The alcoholic rehabilitation division maintains the closest relations with other agencies which are interested in treating alcoholics, including Alcoholics Anonymous, Harbor Light of the Salvation Army, and various individuals such as clergymen and employers. If it is believed that a patient can benefit by association with another group, his therapist so recommends.

The clinic is located near the center of Washington and consists of a reconditioned school building, which provides ample space for offices and medical facilities, and which contains a lounge and waiting room together with workshops for occupational therapy.

### Credits and Debits

During the period February 1, 1950, to August 31, 1954, the outpatient clinic registered 2,577 patients, 1,909 of whom voluntarily sought assistance, and 668 of whom were court referrals. In addition, the clinic has treated many hundreds of persons, usually in an acute stage of alcoholic suffering, who were not registered as patients because they made single visits only and did not return for therapy.

In a followup study of 715 patients who had made 3 or more visits to the clinic as of June 30, 1952, the degree of rehabilitation for each patient was measured in terms of improvement in the drinking pattern, social improvement, and psychiatric improvement. Some patients have been followed since the clinic opened on February 1, 1950; for voluntary patients, the average period of observation in the study referred to was 16.6 months; for court-referred patients, 9.1 months. Favorable results in terms of improvement in the patient's drinking pattern, social improvement and/or psychiatric improvement were achieved in approximately 70 percent of the cases treated within each group of voluntary and court-referred patients (*10*).

Thus, in the majority of cases improvement is sustained; the patient continues his weekly therapy, not only for the purpose of maintaining sobriety, but also, as insight deepens, for the purpose of developing a more effective personality. In many cases, there are lapses from sobriety, but ordinarily the intervals become longer and the severity lessens.

The subject of "lapses" has been much discussed and undoubtedly misunderstood. Perhaps the remark of a patient made at a time when the clinic was under criticism sums it up: "If an alcoholic has been sober one day, he has been helped."

Lapses have been known to occur after 10 years of nondrinking. In the experience of the clinic, a very earnest patient recently lapsed for a short period after 7 years of sobriety. Scientific treatment of alcoholism is relatively new; research projects are constantly under way; and in the end, we hope, discoveries will be made which will alleviate the problem of lapses. In the meantime, there is no more reason for failure to treat alcoholic patients than there would be for failure to aid cancer patients because the ultimate cure has not been found.

What has been said and the examples cited show the severity of alcoholism as a disease. In the medical sense, it is a chronic illness with indefinite prognosis; however, recovery with treatment is achieved in many cases. In the social sense, it tends strongly to detach the patient from society and leads to deterioration of his multiple values, cultural, religious, and so on.

During the 4 years the alcoholic rehabilitation program has been in operation, the outpatient clinic has developed to the point of being well equipped to serve the needs of patients who can be treated on an extramural basis. Patients so treated are usually in the nondestitute class and still have family and community ties which they desire to protect. In most instances, they are voluntary applicants for treatment. Since the early alcoholics of today are the destitute, skid row figures of tomorrow, the clinic by performing valuable preventive work in arresting their alcoholism will in the long run benefit the community as well as the individuals concerned.

On the debit side of the ledger, it must be conceded that the program has made scarcely a dent in the alcoholic problem as it presents itself to the municipal court and law enforce-

ment agencies. In addition, the program has been unable to reach and afford proper treatment to many hidden alcoholics of the type who need inpatient care and who do not pass through the courts. The program's effectiveness is further limited by insufficient funds and lack of proper facilities and by the inadequate commitment procedures prescribed by the existing law.

### The Chronic Offenders

The 1947 act (7) directed the commissioners for the District of Columbia to establish and equip a clinic in connection either with some existing hospital or some correctional institution or other facility for the diagnosis, classification, hospitalization, confinement, treatment, and study of persons who are found to be chronic alcoholics. The law authorized the courts, in their discretion, to commit alcoholics who have been arrested on the criminal charge of drunkenness to the clinic for supervision and treatment. Until April 15, 1954, however, it was not possible to commit an alcoholic requiring inpatient care to the clinic because of the lack of proper and adequate treatment facilities.

There is now being tested in the District a new plan which represents the best program of treatment that could be devised within the framework of sections 4 and 8 of the act approved August 4, 1947, and with the financial resources available. On April 15, 1954, the District commissioners, together with officials of the health department, the department of corrections, and the municipal court, inaugurated a program for the commitment of a limited number, not to exceed 25, of alcoholics who have been selected to receive inpatient care at the District of Columbia workhouse at Occoquan, Va.

Four afternoons weekly, psychotherapists, occupational and recreational therapists, social workers, and public health nurses from the clinic collaborate in a "total-push" effort to rehabilitate the patients in the extension clinic of the alcoholic rehabilitation division, which is temporarily set up in the workhouse. Treatment of these committed patients includes individual counseling interviews, physical rehabilitation measures, contact with members of Alcoholics Anonymous, and making arrangements for return of the patients to the community. Such arrangements include the procurement of room and board and vocational assistance. In every instance, plans for continued extramural treatment upon discharge from the workhouse are made. Envisioned is a followup study, for at least 1 year, of every patient committed by the court.

Plans are currently being formulated by the District commissioners to set up a larger rehabilitation center for alcoholics at Muirkirk, Md., which will house 100 patients. When this project at Muirkirk will be realized cannot be gauged at this time. All participating in the pilot project of committing alcoholics agree that the above approach is the most rational and promising method of dealing with the court-offender, homeless type of alcoholic.

With the exception of this newly inaugurated and obviously limited program at the Occoquan workhouse, however, the courts are currently unable to "commit" alcoholics to the alcoholic rehabilitation clinic in the District because of the lack of adequate inpatient facilities, although harassed judges, confronted with offenders who have been arrested 150 times or more for drunkenness, have often threatened to do so. The present practice is to "refer" to the clinic defendants in drunk cases who have been interviewed by a social worker and who are considered good material for rehabilitation under this program. The number who are considered capable of rehabilitation by outpatient care alone is very small—approximately 2 cases a week. These are persons who express a desire for help, recognize that their life situation in relation to drink demands change, and who appear to the social worker hopeful for successful rehabilitation. Of course, these 2 cases a week are but a "drop in the bucket" of the total alcoholic morbidity coming before the courts.

### The "Drunk Court"

Most of the alcoholics coming before the municipal court of the District are still dealt with under the code provision which forbids

public intoxication and prescribes penalties of fine or imprisonment. According to an unpublished report of the chief judge of the municipal court to the president of the District Board of Commissioners, 75 percent of all matters coming before the court in the fiscal year 1953—21,988 cases—involved persons arrested for intoxication. As a result of this situation, a section of the court is popularly termed "the drunk court."

Recidivism among persons arrested and sentenced for intoxication has been a matter of concern to the law enforcement agencies of every jurisdiction. Studies have been made in the District of Columbia with the usual melancholy finding that, by and large, arrests for intoxication are accounted for by chronic court repeaters whose more or less constant relationship with the police and correctional departments constitutes a revolving door treatment.

In the report referred to above, the chief judge of the municipal court of the District estimates that repeaters represented more than 90 percent of the 21,988 intoxication cases heard in 1953. Of these cases, 19,268 were disposed of by commitment to the District jail or workhouse for an average sentence of 28 days.

For purposes of this report, records were examined for 139 persons charged with public intoxication who appeared before the criminal division of the District of Columbia municipal court on March 8, 1954. Only 10 of the group had never been arrested before. The remaining 129 were repeaters with records of previous arrests as follows:

| *Previous arrests for intoxication* | *Number of persons* |
|---|---|
| 1–5 | 47 |
| 6–25 | 42 |
| 26–50 | 22 |
| 51–100 | 16 |
| 101–200 | 1 |
| 201–300 | 1 |
| Total | 129 |

A similar study was made of 529 prisoners in correctional institutions of the District of Columbia who were serving sentences for intoxication. It was found that 45 members of the group had never been committed before, while 484 had served previous sentences as a result of drunk charges. The record of previous commitments for the latter group was as follows:

| *Previous commitments for intoxication* | *Number of persons* |
|---|---|
| 1–4 | 83 |
| 5–9 | 84 |
| 10–14 | 58 |
| 15–19 | 39 |
| 20–29 | 60 |
| 30–39 | 32 |
| 40–49 | 30 |
| 50–74 | 56 |
| 75–99 | 23 |
| 100–124 | 13 |
| 125–149 | 3 |
| 150 or more | 3 |
| Total | 484 |

When 5, 6, and 7 commitments a year are not uncommon for repeaters, it is no overstatement to say that under the present system a large number of alcoholics who are sick people according to the language of the 1947 act are spending a major portion of their time in jail and receiving no treatment.

The annual cost of salaries and supplies necessary to the operation of the drunk court in the District of Columbia is approximately $76,200. An associate justice devotes three-quarters of his time to intoxication cases, and 19 other employees devote either full or part time thereto. In view of the doubtful results achieved through the penal approach, it may well be questioned whether this expenditure of time, talent, and money is justified.

As expressed by Chief City Magistrate John M. Murtagh of New York City in a recent speech advocating improved legislation and facilities for the treatment of alcoholism: "We in the criminal judiciary have in the past allowed society to assign to us the responsibility for a tragic human problem which neither we nor anyone else understood. We have blindly acquiesced in a barbaric system that gave us prison bars as the therapeutic approach and denied us even the most modest staff to inquire into the nature of the problem."

Persons arrested on the charge of intoxication do not in every instance pass through the courts. If the offender is able to post $10 collateral and wishes to forfeit the same, he may procure his release without appearing in court. According to the annual report of the chief of police for the fiscal year 1953, 38,333 arrests were made in Washington, D. C., during the

year on the charge of intoxication (*11*). Assuming a maximum of 20 percent who are court offenders among the District's alcoholic population, these 38,333 arrests would be accounted for by 7,380 persons, an average of slightly more than 5 arrests for each.

### Toward Sensible Rehabilitation

The hidden alcoholics are another tragedy, less dramatic but equally poignant. These individuals are having serious trouble with alcohol, but they still have homes, families, and, in some instances, jobs. They are unwilling to give up alcohol, which is their major solace in the face of anxiety and depression, although everyone around them can see the handwriting on the wall. Such persons have little contact with the police. Arrest for intoxication, when it occurs, brings an anxious relative or friend to the precinct house to post collateral and procure release. During the fiscal year 1953, collateral amounting to $148,525 was posted and forfeited in the cases of persons arrested for intoxication—another unproductive expenditure insofar as recovery from alcoholism is concerned. There are many hidden alcoholics who need inpatient care for an indeterminate period, as much as persons suffering from other illnesses of an emotional nature, but there is no public institution in the District which is equipped to provide such care in the case of alcoholic patients.

Any attempt to solve the problem of alcoholism must begin with a serious facing up to the deficiencies of the penal approach and a search for more promising methods of treatment. Alcoholism is a problem national in scope. Lives, families, and careers are being destroyed, and many millions of dollars as well are wasted annually, while very little effort is being expended to get at the source of the problem and to alleviate its destructive effects.

Only an increasing awareness on the part of the general public, State and local officials, and our national representatives can set us on the road to meet with impact the vicious challenge which alcoholism presents.

Specifically, in terms of additional inpatient facilities, the alcoholic rehabilitation program in the District of Columbia, and in countless other major cities in the United States as well, needs the following:

A hostel or halfway house, a boarding home where alcoholics in the convalescent stage could be admitted and allowed to stay in a controlled environment until well on the way to rehabilitation—a moderate amount would be paid for board and room by those capable of obtaining employment.

A hospital ward for the screening (diagnosis and classification) of alleged alcoholics and for the short-term care of alcoholics in the acute stage of intoxication—arrangements have been completed for a small alcoholic ward in the municipal hospital of the District (the District of Columbia General Hospital), which could be enlarged to serve this purpose.

An institution for long-term treatment of alcoholics and for the custodial care of deteriorated, incurable patients—this should be a hospital, located in a rural area, with sufficient acreage for farming and workshops for occupational therapy and vocational training.

### Suggested Commitment Procedures

In those localities which are ready for a changeover from criminal to civil methods of dealing with alcoholism, essentially a problem of public education and of correcting or modifying local legislation, it is suggested that careful consideration be given to the creation of a commission on alcoholism, similar to the local commissions on mental health, which have been established in some jurisdictions including the District of Columbia (*12*). Such commission would be responsible for holding fact-finding hearings in the cases of alleged chronic alcoholics and making recommendations to the court for commitment, treatment on an outpatient basis, and discharge for the alcoholic who has not progressed to the chronic stage, or some other appropriate disposition. Such commission would be an arm of the courts and would act in aid thereof. As in mental health cases, orders for commitment of chronic alcoholics would be issued by the court on the basis of the findings and recommendation of the commission on alcoholism.

Although not essential, the chairman of any such commission might well be a lawyer, experienced in the field of psychiatry, whose duty would be to direct the proceedings and hearings in such manner as to assure fairness. The commission's other members should be psychiatrists and psychiatric social workers with specialized experience in the field of alcoholism.

A judicial trial in the ordinary sense is not appropriate in determining whether a person is a chronic alcoholic in need of institutional care and is not required by due process of law (*13*). A commission composed of persons with specialized knowledge of alcoholism could be expected to possess an expertise which would make for just and wise findings and recommendations. As Henry Weihofen has so succinctly stated in discussing commitment procedures without judicial trial—he is referring specifically to mental illness (*14*):

"The only argument made in favor of full hearing in these cases is that sane persons might otherwise find themselves committed. But since no one would suggest that more than a small percentage of commitment cases involve anything improper, it seems a blunderbuss method to require elaborate formalities in all cases, in order to avoid abuse in a few. Easy and informal admission is the most humane to the patient and least expensive for the taxpayer. The relatively rare cases where the patient wants to contest the commitment order could be handled by allowing a full hearing on appeal."

It would, of course, be necessary that the legislative act setting up a commission on alcoholism guarantee to all affected thereby the essentials of due process of law—adequate notice of the hearing to be held by the commission, the opportunity to present a defense, and the right to counsel. In addition, as Weihofen suggests, there should be a right of appeal to the court for a trial de novo, if the patient so requests.

Any new or revised laws dealing with the commitment of alcoholics should contain a provision similar to that contained in the District of Columbia legislation on mental health (*12*), whereby a petition may be filed by a relative, friend, physician, police, or welfare officer, requesting that a hearing be held and the individual committed to an institution for alcoholism if it is found that he requires inpatient care.

Periodic examinations should be required after admission to the hospital, whether as a result of commitment or as a voluntary act, in order to determine the need for continued hospitalization. Outright discharge, or transfer to the suggested convalescent home, should be authorized as soon as the patient's condition warrants. In other words, the requirement of medical certification as to the need for detention and hospitalization should be regarded as a continuing one, which is subject to change as progress is made toward rehabilitation.

Since institutions for the care of the mentally and emotionally ill are generally overcrowded, the fear of "railroading," or illegal detention, is probably greatly exaggerated. However, under our system of jurisprudence, the writ of habeas corpus is available, in addition, to anyone who claims that he is being deprived of his liberty illegally.

Ideally, the term of commitment should be indeterminate, as is usual in mental health cases. Those who advocate a relatively short maximum commitment, such as 90 days, fail to recognize the complexity of alcoholism as a disease. It is true that 90 days would be sufficient in many cases, but where the disease is far advanced, where the patient has lost home, family, and job ties, where self-respect is low and life values have deteriorated, longer treatment will be required in order to effect rehabilitation.

There are obvious advantages in providing in the legislation for voluntary admission to inpatient facilities. A person believing himself to be a chronic alcoholic when admitted upon his own application could not be restrained from leaving if he chose to do so. However, he should be required to give a few days' notice of his intention to leave in order to prevent a too hasty decision.

## Conclusion

As phrased by Judge Murtagh in the speech referred to, alcoholism is a "tragic human problem," psychiatric in its nature, with medical and social aspects, to which penal procedures have been drearily and futilely applied. Clinics throughout the country, such as the one maintained by the alcoholic rehabilitation division of the District of Columbia Department of Public

Health, are doing what they can, but additional facilities, particularly for inpatient treatment, are desperately needed, and could be provided if the money which is now being used for the processing of intoxication cases as criminal were diverted to more enlightened purposes. The time will come when there is understanding of the problem, with public demand for change.


**REFERENCES**

(*1*) The establishment of diagnostic and guidance clinics for inebriates in Connecticut—"Yale Plan Clinic" (editorial): Quart. J. Stud. on Alcohol 4: 496–508 (December 1943).

(*2*) Zappala, A.: The rehabilitation of alcoholic patients in the District of Columbia. Med. Ann. District of Columbia 23: 91–95 (1954).

(*3*) Bacon, S. D.: Alcoholism: 1. Nature of the problem. 2. Its extent, therapy, and prevention. Fed. Probation 11: 4–7; 24–32 (January–March and April–June, 1947).

(*4*) Jellinek, E. M., and Keller, M.: Rates of alcoholism in the United States of America. Quart. J. Stud. on Alcohol 13: 49–59 (1952).

(*5*) Landis, B. Y.: Some economic aspects of alcohol problems. Quart. J. Stud. on Alcohol 6: 59 (1945).

(*6*) 25 District of Columbia Code 128 (Supp. 2, 1953).

(*7*) 24 District of Columbia Code 501–514 (1951).

(*8*) Legislation for the treatment of alcoholics. Stanford Law Rev. 2: 515 (1950).

(*9*) 25 District of Columbia Code 111a (1951).

(*10*) Wexberg, L. E.: The outpatient treatment of alcoholism in the District of Columbia. Quart. J. Stud. on Alcohol 14: 514–524 (1953).

(*11*) Washington (D. C.) Metropolitan Police Department: Annual report, fiscal year 1953.

(*12*) 21 District of Columbia Code 301–333 (1951; Supp. 2, 1953).

(*13*) Constitutionality of non-judicial commitment. Stanford Law Rev. 3: 109 (1950).

(*14*) Weihofen, H.: Hospitalizing the mentally ill. Mich. Law Rev. 50: 837, 853 (1952).


## Epidemiology Course for Nurses

The Communicable Disease Center, Public Health Service, is offering a refresher course in communicable disease control to public health nurses and instructors in communicable disease nursing, May 16 through June 3, 1955, in Atlanta, Ga.

The course is designed to increase the technical knowledge and skills of nurses in the prevention and control of communicable diseases. Epidemiological principles and techniques will be emphasized.

Field experience under supervision will be available to a limited number of students following the completion of the course.

For further information and application, write to your State health department director of public health nursing or to the Chief, Communicable Disease Center, Attention: Chief Nursing Consultant, 50 Seventh Street, N. E., Atlanta, Ga.